Anthem HealthKeepers Plus
Offered by HealthKeepers, Inc.

Prior Authorization (PA) Form: Hereditary Angioedema (HAE) Medications

HealthKeepers, Inc. | Anthem HealthKeepers Plus Medicaid products

If the following information is not complete, correct, or legible, the PA process can be delayed .
Please use one form per member.

Member information

Last name: ______________ **First name:** ______________

Medicaid ID number: ______________ **Date of birth:** ___ - ___ - ____

Gender: ☐ **Male** ☐ **Female** **Weight in kilograms**: ______________

Prescriber information

Last name: ______________ **First name:** ______________

NPI number: ______________

Phone number: ___ - ___ - ____ **Fax number:** ___ - ___ - ____

Drug information

Preferred medications (quantity limits):

☐ **Cinryze**™ – 20 vials per 34 days
☐ **Berinert**® – 4 vials per attack (plus 4 for emergency)
☐ **icatibant**: 1 dose per attack (plus 1 for emergency)
☐ **Sajazir™**: 1 dose per attack (plus 1 for emergency)
☐ **Kalbitor**® – 3 vials per attack (plus 3 for emergency) (see Black Box warning below)

Because of the risk of anaphylaxis, KALBITOR® should only be administered by a healthcare professional with appropriate medical support to manage anaphylaxis and hereditary angioedema.

Non-preferred Medications (Quantity Limits):

☐ **Firazyr**®: 1 dose per attack (plus 1 for emergency)
☐ **Orladeyo**™: 34 capsules per 34 days
☐ **Ruconest**®: 2 vials per attack (plus 2 for emergency)
☐ **Takhzyro**®: 2 vials per 28 days
☐ **Haegarda**®: 2,000 IU SDV kit (16 kits per 28 days) and 3,000 IU SDV kit (8 kits per 28 days)

Drug Name/Form: ______________

Strength: ______________

Dosing Frequency: ______________

Length of Therapy: ______________

Quantity per Day: ______________

(Form continued on next page.)

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Member's last name: | | | | | | | | | | | | |

Member's first name: | | | | | | | | | | | | |

Diagnosis and medical information

1. Has the recipient's diagnosis of HAE been confirmed by C1 inhibitor (C1-INh) deficiency or dysfunction (type I or II HAE) as documented by one of the following:
    - C1-INh antigenic level below the lower limit of normal; **or**
    - C1-INh functional level below the lower limit of normal?

   ☐ Yes ☐ No

2. Was the medication prescribed by, or in consultation with, a specialist in allergy, immunology, hematology, pulmonology, or medical genetics?

   ☐ Yes ☐ No

TREATMENT OF ACUTE HAE ATTACKS

Berinert® (C1 esterase inhibitor), Firazyr® (icatibant), icatibant, Kalbitor® (ecallantide), Ruconest® (C1 esterase inhibitor), Sajazir™(icatibant)

1. Will the requested medication be used as mono therapy to treat acute HAE attacks?

   ☐ Yes ☐ No

PROPHYLAXIS OF HAE ATTACKS

Cinryze® (C1 esterase inhibitor), Haegarda® (C1 estarase inhibitor), Orladeyo® (berotralstat), Takhzyro® (ianadelumab-flyo)

1. Will the requested medication be used for prophylaxis of HAE attacks?

   ☐ Yes ☐ No

______________________________ ______________

Prescriber Signature (Required) **Date**

By signature, the physician confirms the above information is accurate and verifiable by member records.

Please include all requested information; Incomplete forms will delay the PA process.
Submission of documentation does **not** guarantee coverage.

The completed form may be **faxed to 844-512-7020.**